AH.

CompliMed
When your Medical Aid is not enough

HEALTH CLAIM FORM 2011

ambledown

COMPLIMED MUST BE NOTIFIED OF ANY CLAIM IN WRITING WITHIN 6 MONTHS FROM DATE OF TREATMENT OF SUCH INCIDENT.

PLEASE ATTACH THE FOLLOWING DOCUMENTS APPLICABLE TO THE DATE OF INCIDENT:
(Failure to attach all applicable documentation to this claim form will cause undue delay in the processing thereof.)

THE FOLLOWING REQUIREMENTS ARE **COMPULSORY**

- ☐ HOSPITAL ACCOUNT (FIRST FOUR PAGES ONLY)
- ☐ DOCTORS ACCOUNTS
- ☐ MEDICAL AID CLAIMS STATEMENT

PERSONAL PARTICULARS

APPLICANT (MEMBER)

COMPLIMED POLICY NO

SURNAME TITLE Mr

FIRST NAMES

DATE OF BIRTH

ID NUMBER

MEDICAL AID Discovery OPTION LA Health MEMBERSHIP NO

CONTACT DETAILS Complimed will correspond with you via e-mail & cellphone only. Kindly ensure that these details are completed in full

POSTAL ADDRESS

POSTAL CODE

POSTAL CODE

TELEPHONE NUMBERS

HOME WORK CELL

EMAIL ADDRESS

PARTICULARS OF PATIENT

SURNAME MALE FEMALE X

FIRST NAMES

DATE OF BIRTH

ID NUMBER

RELATIONSHIP TO MEMBER

☐ SELF ☒ SPOUSE ☐ CHILD

IMPORTANT NOTE: CHILD DEPENDANTS WHO ARE 21 OR OLDER MUST SUBMIT PROOF OF FULL TIME STUDENTSHIP

PLEASE COMPLETE ON PAGE 2 FULL AND COMPREHENSIVE DETAILS PERTAINING TO THE ABOVE CLAIM

DETAILS OF CLAIM - PLEASE COMPLETE THE FOLLOWING IN FULL

DIAGNOSIS: Cancer of forehead

HOSPITAL NAME: Entabeni

DATE OF HOSPITALISATION: FROM [redacted] TO [redacted]

NAME OF ADMITTING DOCTOR: Dr [redacted]

DOCTOR'S PRACTICE NUMBE[redacted] TEL [redacted]

NAME OF FAMILY DOCTOR [redacted] TEL [redacted]

Date of service	Service provider	Amount charged	Paid by medical aid	Shortfall
[redacted]		R 16 628,85	R 5485,50	R 11 143,35
YYYYMMDD		R	R	R
YYYYMMDD		R	R	R
YYYYMMDD		R	R	R

PAYMENT INSTRUCTIONS

IMPORTANT NOTE: BENEFITS MAY NOT BE PAID DIRECTLY INTO THE PRACTIONERS ACCOUNTS

BENEFITS WILL ONLY BE PAID BY ELECTRONIC FUND TRANSFER INTO THE BANK ACCOUNT AS DETAILED BELOW

ACCOUNT HOLDERS NAME [redacted]

ACCOUNT NUMBER [redacted] (11 Digits Maximum)

BANK [redacted]

BRANCH NAME [redacted] BRANCH CODE [redacted]

ACCOUNT TYPE [ ] CURRENT [ ] TRANSMISSION [X] SAVINGS (No Credit Card Accounts Accepted)

Signature of Account Holder

Signature of Principal (If different from Account Holder)

DECLARATION

(1) I/We hereby declare that the person mentioned under claimant details is nominated under the abovementioned policy, that all the particulars given are true and complete, and that the hospitalisation was not wholly or partly, directly or indirectly, caused by the contingencies mentioned in both the General and Specific exceptions as well as any addendum attached to the policy in question,

In particular, I'm aware that this claim does not fall into one of the following 3 exceptions:

1. **Pregnancy or childbirth during the first 12 months of the contract.**
2. **For a period of 12 months from date of inception, any condition for which an insured person received treatment or advice by a Medical Practitioner within a 12-month period prior to the inception date of that insured person, unless such a condition was directly attributable to an Accident (as defined).**
3. **A 3-month general waiting period will apply from date of inception for all procedures other than due to an accident.**

(2) I/We further declare that the above statements are true and that I/we have withheld no material information and that I/we undertake to furnish any documentation which may be required by Hollard Group Risk, a division of The Hollard Insurance Company Limited and Hollard Life Assurance Company Limited.

(3) I/We expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who attended or examined the claimant, or any institution in which the claimant received treatment, to disclose any knowledge or information which was thereby acquired and agree that this authority shall remain in force until cancelled in writing.

(4) I/We authorise all such persons or agencies to furnish any information in their possesion to Hollard Group Risk, a division of The Hollard Insurance Company Limited and a division of Hollard Life Assurance Company Limited.

Applicant / Principal Member (Name and Surname)

Signature

Date